



TOBY DOUGLAS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



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**QUARTERLY PROGRESS REPORT FOR THE PERIOD 10-01-2013 THROUGH
12/31/2013 FOR THE CALIFORNIA BRIDGE TO REFORM DEMONSTRATION (11-W-00193/9)**

Dear Ms. Gerrits, Mr. Nelb, and Ms. Nagle:

Enclosed is the Quarterly Progress Report required by Paragraph 20 and Attachment I of the Special Terms and Conditions of California's section 1115 *Bridge to Reform Demonstration* (11-W-00193/9). This is the second quarterly progress report for Demonstration Year Nine, which covers the period from October 1, 2013 through December 31, 2013.

If you or your staff have any questions or need additional information regarding this report, please contact Danielle Stumpf at (916) 324-9457.

Sincerely,


Toby Douglas
Director

Enclosure

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TITLE:

California Bridge to Reform Demonstration (11-W-00193/9)

Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Demonstration Year: Eight (07/01/12-06/30/13)

Fourth Quarter Reporting Period: 04/01/2013-06/30/2013

INTRODUCTION:

AB 342 (Perez, Chapter 723, Statutes of 2010) authorized the Low Income Health Program (LIHP) to provide health care services to uninsured adults, ages 19 to 64, who are not otherwise eligible for Medi-Cal, with incomes up to 133 percent of the Federal Poverty Level (FPL). Further, to the extent Federal Financial Participation (FFP) is available, LIHP services may be made available to individuals with incomes between 134%-200% of the FPL.

SB 208 (Steinberg/Alquist, Chapter 714, Statutes of 2010) authorized the Department of Health Care Services (DHCS) to implement changes to the federal Section 1115 (a) Comprehensive Demonstration Project Waiver titled, *Medi-Cal Hospital/Uninsured Care Demonstration (MCH/UCD)* that expired on August 31, 2010. The bill covered implementation of all Section 1115 Waiver provisions except those sections addressing the LIHP projects, which are included in AB 342.

ABX4 6 (Evans, Chapter 6, Statutes of 2009) required the State to apply for a new Section 1115 Waiver or Demonstration Project, to be approved no later than the conclusion of the MCH/UCD, and to include a provision for enrolling beneficiaries in mandatory managed care.

On June 3, 2010, California submitted a section 1115 Demonstration waiver as a bridge toward full health care reform implementation in 2014. The State's waiver will:

- Create coordinated systems of care for Seniors and Persons with Disabilities (SPDs) in counties with new or existing Medi-Cal managed care organizations through the mandatory enrollment of the population into Medicaid managed care plans
- Identify the model or models of health care delivery for the California Children Services (CCS) population that would result in achieving desired outcomes related to timely access to care, improved coordination of care, promotion of community-based services, improved satisfaction with care, improved health outcomes and greater cost-effectiveness
- Phase in coverage in individual counties through LIHP for the Medicaid Coverage Expansion (MCE) population—adults aged 19-64 with incomes at or

below 133 percent of the FPL who are eligible under the new Affordable Care Act State option

- Phase in coverage in individual counties through LIHP for the Health Care Coverage Initiative (HCCI) population—adults between 133 percent to 200 percent of the FPL who are not otherwise eligible for Medicaid
- Expand the existing Safety Net Care Pool (SNCP) that was established to ensure continued government support for the provision of health care to the uninsured by hospitals, clinics, and other providers
- Implement a series of infrastructure improvements through a new funding sub-pool called the Delivery System Reform Incentive Pool (DSRIP) that would be used to strengthen care coordination, enhance primary care and improve the quality of patient care
 - Note: Reporting to CMS for DSRIP is done on a semi-annual and annual aggregate reporting basis and will not be contained in quarterly progress reports.

On January 10, 2012, the State submitted an amendment to the Demonstration, approved March 31, 2012, to provide Community Based Adult Services (CBAS)—outpatient, facility-based program that delivers skilled-nursing care, social services, therapies, personal care, family/caregiver training and support, means, and transportation—to eligible Medi-Cal beneficiaries enrolled in a managed care organization. Beneficiaries who previously received Adult Day Health Care Services (ADHC), and will not qualify for CBAS services, will receive a more limited Enhanced Case Management (ECM) benefit.

On June 28, 2012, CMS approved an amendment to the Demonstration to:

- Increase authorized funding for the Safety Net Care Uncompensated Care Pool in DY 7 by the amount of authorized but unspent funding for HCCI and the Designated State Health Programs in DY 6.
- Reallocate authorized funding for the HCCI to the Safety Net Care Uncompensated Pool for DY 7.
- Establish an HIV Transition Program within the DSRIP for “Category 5” HIV transition projects to develop programs of activity that support efforts to provide continuity of quality and coverage transition for LIHP enrollees with HIV.

SENIORS AND PERSONS WITH DISABILITIES (SPD)

Seniors and Persons with Disabilities (SPD) are persons who derive their eligibility from the Medicaid State Plan and are either: aged, blind, or disabled.

According to the Special Terms and Conditions of this Demonstration, DHCS may mandatorily enroll SPDs into Medi-Cal managed care programs to receive benefits. This does not include individuals who are:

- Eligible for full benefits in both Medicare and Medicaid (dual-eligible individuals)
- Foster Children
- Identified as [Long Term Care \(LTC\)](#)
- Those who are required to pay a “share of cost” each month as a condition of Medi-Cal coverage

Starting June 1, 2011, the following counties began a 12-month period in which approximately 380,000 SPDs were transitioned from fee-for-service systems into managed care plans: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.

The State will ensure that the Managed Care plan or plans in a geographic area meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the State, as required by 42 CFR 438 and approved by CMS.

The SPD transition is part of DHCS’s continuing efforts to fulfill the aims of the Patient Protection and Affordable Care Act (ACA). Medi-Cal’s goals for the transition of SPDs to an organized system of care are to: ensure beneficiaries receive appropriate and medically necessary care in the most suitable setting, achieve better health outcomes for beneficiaries, and realize cost efficiencies. Managed care will allow DHCS to provide beneficiaries with supports necessary to enable SPDs to live in their community instead of in institutional care settings, reduce costly and avoidable emergency department visits, as well as prevent duplication of services.

DHCS contracts with managed care organizations to arrange for the provision of health care services for approximately 4.27 million Medi-Cal beneficiaries in 27 counties.

DHCS provides three types of managed care models:

1. Two-Plan, which operates in 14 counties.
2. County Organized Health System (COHS), which operates in 11 counties.
3. Geographic Managed Care (GMC), which operates in two counties.

DHCS also contracts with one prepaid health plan in one additional county and with two specialty health plans.

Enrollment information:

The “mandatory SPD population” consists of Medi-Cal-only beneficiaries with certain aid codes who reside in all counties operating under the Two-Plan Model (Two-Plan) and Geographic Managed Care (GMC) models of managed care. The “existing SPD population” consists of beneficiaries with certain aid codes who reside in all counties operating under the County-Organized Health System (COHS) model of managed care, plus Dual Eligibles and other voluntary SPD populations with certain aid codes in all counties operating under the Two-Plan and GMC models of managed care.

**TOTAL MEMBER MONTHS FOR MANDATORY SPDs BY COUNTY
October 2013 – December 2013**

County	Total Member Months
Alameda	89,441
Contra Costa	47,998
Fresno	69,402
Kern	55,348
Kings	7,548
Los Angeles	592,922
Madera	7,320
Riverside	95,000
San Bernardino	111,626
San Francisco	52,336
San Joaquin	50,868
Santa Clara	67,702
Stanislaus	31,807
Tulare	32,244
Sacramento	113,026
San Diego	119,911
Totals	1,544,499

**TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
October 2013 – December 2013**

County	Total Member Months
Alameda	38,628
Contra Costa	14,495
Fresno	19,900
Kern	12,520

County	Total Member Months
Kings	1,811
Los Angeles	187,443
Madera	1,787
Marin	18,300
Mendocino	17,248
Merced	45,403
Monterey	43,778
Napa	13,278
Orange	323,251
Riverside	30,143
Sacramento	34,364
San Bernardino	31,793
San Diego	37,077
San Francisco	22,030
San Joaquin	12,455
San Luis Obispo	24,609
San Mateo	66,667
Santa Barbara	43,552
Santa Clara	29,670
Santa Cruz	28,723
Solano	54,798
Sonoma	49,125
Stanislaus	5,223
Tulare	8,886
Ventura	76,960
Yolo	24,118
Totals	1,109,118

Enrollment (October 2013 – December 2013)

During the quarter, mandatory SPDs had an average choice rate of 48.28%, an auto-assignment default rate of 35.48%, a passive enrollment rate of 1.73%, a prior-plan default rate of 1.22%, and a transfer rate of 10.77%. In December, overall SPD enrollment in Two-Plan and GMC counties was 509,676 (point-in-time), a 0.77% decrease over September's enrollment of 505,797. For monthly aggregate and Medi-Cal managed care plan (MCP)-level data, please see the attachment "DY9-Q2 Defaults Transfers 2Plan GMC."

Outreach/Innovative Activities:

With funding from the California HealthCare Foundation (CHCF), Medi-Cal Managed Care Division (MMCD) engaged a vendor, Navigant, to create the MMCD Performance Dashboard for the Medi-Cal Managed Care program. The dashboard will help DHCS and its stakeholders to better observe and understand MCP activities on all levels: statewide, by managed care model (i.e., COHS, GMC, and Two-Plan), and within an individual MCP. It will include metrics submitted by MCPs that quantify and track quality of care, enrollee satisfaction, enrollee utilization, finances, care coordination, and continuity of care. It will also stratify reported data by beneficiary populations including Medi-Cal-only SPDs.

MMCD has developed a public version of the MMCD Performance Dashboard beginning with the Quarter 3, 2013 edition. MMCD will be posting the public dashboard to the DHCS website in early 2014, and will be conducting a webinar with stakeholders to discuss the dashboard in February 2014.

Operational/Policy Issues:

Network Adequacy

Between October 2013 and December 2013, the Department of Managed Health Care (DMHC) completed a provider network review of all Two-Plan and GMC model MCPs. DMHC's reviews, based on quarterly provider network reports, provide DHCS with an updated list of providers SPDs may contact to receive care. DMHC conducted a thorough review of each MCP's provider networks and identified no access-to-care issues.

Consumer Issues:

Section 1115 Medicaid Waiver Stakeholder Advisory Committee

On November 20, 2013, DHCS's Section 1115 Medicaid Waiver Stakeholder Advisory Committee (SAC) convened and discussed the following items:

Affordable Care Act Coverage Expansion 2014

The single streamlined application for Medi-Cal and Covered California is complete and available on the DHCS and Covered California websites in several languages; DHCS will ask advocacy communities to help assure translations of this document are correct. The length of the application is only 2–3 pages for a single person, and the balance of the application is to enroll family members.

Based on feedback, DHCS changed the application to clarify the text and re-order the questions. Also, DHCS added information on income limits and the federal poverty level to help applicants understand their eligibility. The application now allows an applicant to identify his or her choice of health plan for Medi-Cal or Covered California.

The Health Care Options “Choice Enrollment” form includes new arbitration language so enrollees can easily identify it when they choose a health plan for Medi-Cal or Covered California. Currently, the online application and the paper application do not match; DHCS will ensure they match each other at a later date. DHCS continues to observe how enrollees and enrollment counselors use the paper application. DHCS will use this information and periodically incorporate changes to the application and its use. DHCS will work to ensure that trainers of enrollment counselors update their training modules. DHCS will coordinate these changes with Covered California. Covered California will make payments for both Covered California applications and for successful Medi-Cal applications. The County Medical Services Program (CMSP) part of the application does not apply to all of the CMSP counties; some CMSP counties maintain unique applications.

DHCS is working to determine the precise amount of enrollment grants it needs in order to contact hard-to-reach target populations. DHCS must also determine if its efforts to secure enrollment grants might supplant its efforts to secure other grant funding. DHCS must distinguish what activities it would fund with Medi-Cal money and whether it currently uses other funds for those activities.

Coordination at the local level and focus on retention and utilization are factors in the selection. The funding is \$26.5 million from the California Endowment (TCE), matched by federal funds for outreach and in-person assistance for the Medi-Cal effort. Counties are the first priority, so based on the applications and funding in this round, DHCS will determine if there will be a second round for applications from other entities. Medi-Cal has no open enrollment—it is always available. However, DHCS recognizes that during the Covered California open enrollment period, some people apply who are now eligible, and others apply who are not eligible until January.

DHCS incorporated this into the enrollment application so that we can process each category according to the enrollee’s eligibility now or in January. Other applications that are coming in electronically through Covered California may indicate information such as a disability and may be eligible for Medi-Cal now. These applications are going to counties for review and determination of whether they can be processed under current rules or under rules for 2014. Consumers are getting coverage based on both sets of eligibility rules. There are many avenues for submitting applications through service centers and others. This is a special period before the interface is fully implemented. DHCS has systems in place to ensure applications are processed.

Covered California

Certified Enrollment Counselors (CEC) Training Status:

DHCS recently reviewed the training module and sent extensive changes back to Covered California. DHCS wants to balance access to information from fraudulent assistance. DHCS assumed responsibility for this task during the transition of the Healthy Families Program to Medi-Cal Managed Care. We will make it clear that the Certified Application Assister (CAA) process will come under the Certified Enrollment Counselors (CEC) process, and we will work on the messaging with Covered California.

DHCS developed a side-by-side process for CAA and CEC to help those entities understand their different requirements. This comparison is posted on the outreach and enrollment website.

Default for the Newly Eligible

When a consumer enrolls in any of the access points, online or county or by a paper, the normal process will occur. They will be put into Fee-for-Service (FFS) and receive a packet from Health Care Options to choose a health plan, then move into managed care later in April. Beginning in April 2014, once the online system is fully implemented, consumers will be enrolled and go directly into a health plan. DHCS is aware of the sequencing issues, and is working on loading the information into Medi-Cal Eligibility Data System (MEDS). That will trigger the Benefits Identification Card (BIC) being processed, and the enrollee will then be mailed a Health Care Options packet prompting the member to choose a health plan. DHCS is working through the IT systems to accomplish this. While it is still in process, the goal is to do this as soon as possible.

Special Concerns in Rural Areas

DHCS transitioned eight counties into Partnership Health Plan on September 1, 2013. On November 1, 2013, DHCS transitioned an additional 20 counties. DHCS now has managed care in 58 counties (still voluntary in San Benito). The transition is going smoothly. On the Ombudsman call line, only 3% of the calls are coming from these counties. DHCS is seeing some issues with provider networks. The Department of Managed Health Care (DMHC) made some exceptions to time/distance requirements for provider networks. The networks will continue to grow, but it is unlikely that the providers will be exactly the same as FFS.

DHCS transitioned children and parents from the Healthy Families Program; single adults from the Low-Income Health Program will transition on Jan 1, 2014. DHCS's goal is to transition dual-eligible SPD populations in the spring of 2014, upon approval from its federal partners. Dual Eligibles will be voluntary enrollees except in counties operating under the COHS model.

Express Lane

The Affordable Care Act (ACA) legislation included options for California to implement express enrollment into Medi-Cal. The State requested the Centers for Medicare & Medicaid Services (CMS) approval to move forward for some populations. For Cal-Fresh, DHCS identified 600,000 people between the ages of 19–64 who can be express-enrolled into Medi-Cal. DHCS is working with the County Welfare Directors Association (CWDA) and the Department of Social Services to develop the procedures for this, and plans to have a stakeholder meeting in January to get feedback. DHCS expects CMS approval shortly.

Hospital Presumptive Eligibility

DHCS is in the process of finalizing the application for Hospital Presumptive Eligibility for those presenting in the hospital and identified as eligible through consumer self-attestation as to income and residency. DHCS is working on a training program for

the hospitals and is finalizing the system for the program. DHCS will leverage the online Child Health and Disability Prevention (CHDP) system for Hospital Presumptive Eligibility. DHCS is planning to have a stakeholder convening in December and will be operational January 1, 2014.

AB85 Update

DHCS Presentation slides are available at:

<http://www.dhcs.ca.gov/Pages/November202013SacMeeting.aspx>

Annually in January and May, DHCS will project the amount of health realignment funding for indigent care it will redirect on a county-by-county basis to fund social services programs. DHCS's calculation of this amount will account for budget uncertainties and the need for viable county safety nets and public health services. The Department reviews each county's costs and has some built-in incentives in its calculation. There is, however, a cap to the funding amounts. DHCS built in a cost-containment limit for unavoidable costs, such as those brought about by a court order. There is also a process for a county to petition for a change to its allocation for any reason.

DHCS is collecting information on what services the legislation covers, how to determine eligibility, and how health realignment funds are spent. DHCS will be making that information accessible for external use. Counties have their own choices about how to use and structure indigent care programs. The State's role is to provide transparency. DHCS will provide transparency on what it's collecting from counties and it will continue to discuss this process as it receives data.

Low-Income Health Program Transition

Presentation slides is available at:

<http://www.dhcs.ca.gov/Pages/November202013SacMeeting.aspx>

The Low-Income Health Program (LIHP) apologized for a letter it sent out incorrectly noticing consumers, and issued a correction notice on November 12, 2013. DHCS intends for LIHPs and health plans to coordinate their services. LIHP issued a letter to clarify the responsibilities of health plans and continues to encourage health plans to accept LIHP treatment authorizations. The health plans are required to continue treatment that LIHP authorizes at least until the health plan sees the individual. An All Plan Letter from the Medi-Cal Managed Care program specifies that health plans should coordinate care with LIHPs to ensure there is no gap in service. LIHP will soon issue a letter to explain "continuity of care" to its providers in simple language. LIHP intends for provider offices to have this information, which it will explain in a webinar. During the SPD transition, LIHP learned that provider offices are the best way to reach consumers; LIHP continues to consider if there are additional ways to communicate directly to consumers. LIHP is racing toward its transition to the Medi-Cal Managed Care program on January 1, 2014, and intends to continue to improve even beyond that date.

Behavioral Health Services Transition to Medi-Cal Managed Care Update

Presentation slides is available at:

<http://www.dhcs.ca.gov/Pages/November202013SacMeeting.aspx>

We are working on a benefits crosswalk of information that we are sharing with health plans. There is assessment work to be done; DHCS will be providing notices to the health plans.

Substance Use Disorder Services (SUDS) Expansion Update

Presentation slides is available at:

<http://www.dhcs.ca.gov/Pages/November202013SacMeeting.aspx>

The SUDS area is currently FFS, and we need help with expanding the network by encouraging providers to enroll. This is one of the items that will be ongoing beyond January 1, 2014.

Public Comment

DHCS solicited and received comments on improving transparency in how it implements changes to the mental health system. DHCS is looking into the structure of all its stakeholder meetings to see that they include proper representation and solicited input on mental health program changes. DHCS is focusing on ongoing 2014 transitions and has included additional questions on the paper application. DHCS has added questions based on age in the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS). Eligibility for foster care will be granted automatically with follow up by the county to see they are in foster care at age 18.

Full documentation from the meeting is available at:

<http://www.dhcs.ca.gov/Pages/November202013SacMeeting.aspx>.

Office of the Ombudsman (October 2013 – December 2013)

MMCD's Office of the Ombudsman experienced a slight increase in customer calls between the periods July–September 2013 (DY9-Q1) and October–December 2013. During DY9-Q2, the Ombudsman received 17,382 total calls, of which 5,037 concerned mandatory enrollment, and 1,241 were from SPDs. During DY9-Q1, the Ombudsman received 15,076 total calls, of which 5,099 concerned mandatory enrollment, and 1,391 were from SPDs. This represents a 15.3% increase in total calls, a 1.22% decrease in calls regarding mandatory enrollment, and a 10.78% decrease in calls regarding mandatory enrollment from SPDs.

For DY9-Q1, 0.19% of SPD and 0.01% of non-SPD calls concerned access issues. This is a small increase in SPD and non-SPD calls from DY9-Q1, during which 0.11% of SPD calls and 0% of non-SPD calls were related to access issues.

The number of State Hearing Requests (SHRs) decreased for most measures. Total SHRs decreased from 595 in DY9-Q1 to 492 in DY9-Q2. The percentage of SHRs from

SPDs remained at 63%. The number of SHRs regarding the denial of eligibles' requests for exemption from mandatory enrollment into MCPs also decreased from 166 in DY9-Q1 to 106 in DY9-Q2. The percentage of those requests from SPDs decreased from 61% to 56%. There were no SHRs related to access to care or physical access during either quarter.

Quarterly aggregate and MCP-level data is available in the attachments "DY9 Q2 Ombudsman Report" and "DY9 Q2 State Hearing Report."

Medical Exemption Requests (October 2013 – December (2013)

DHCS automated its process for reviewing Medical Exemption Requests (MERs) and Emergency Disenrollment Exemption Requests (EDERs); this electronic system has greatly reduced clinical review time and processing errors and has streamlined DHCS's reporting capabilities. However, DHCS continued to devote a significant amount of staff time and resources during this quarter to the processing of MERs and EDERs. DHCS continued to significantly reduce the number of outstanding MERs and EDERs by reprioritizing staff responsibilities. DHCS's reassignment of nurses from its other divisions and automation of the MER process reduced the number of outstanding MERs to below 100, and DHCS processes EDERs on a daily basis.

The MER Workgroup that was created in 2012, that included key advocates, stakeholders, staff members from DHCS and the State Legislature, have met all their goals and are no longer meeting on a monthly basis, but will continue to meet as needed.

Health Risk Assessment Data (April 2013 – June 2013)

According to the data reported by MCPs operating under the Two-Plan and GMC models, MCPs newly enrolled 26,568 SPDs between April 2013 and June 2013¹. Of those, MCPs stratified 8,803 (33.13%) as high-risk SPDs and 17,001 (63.99%) as low-risk SPDs. Of the high-risk SPDs, MCPs contacted 91.86%, and, of those contacted, 36.73% completed a health risk assessment survey. Of the low-risk SPDs, MCPs contacted 68.85%, and, of those contacted, 29.69% completed a health risk assessment survey. After the health risk assessment surveys were completed, MCPs determined 3,464 SPDs to be in the other risk category, which is 13.08% of the total enrolled in the quarter. Quarterly aggregate and MCP-level data is available in the attachment "Q2 2013 Risk Data."

¹Does not include CalViva & Health Net data. CalViva's administrator, Health Net, is working to re-implement the SPD Risk Assessments and will implement reporting processes that will allow them to provide a complete report in Q4.

Continuity of Care Data (July 2013 – September 2013)

According to the data reported by MCPs operating under the Two-Plan and GMC models, SPDs submitted 849 continuity of care requests between July and September 2013. Of these, MCPs approved 732 requests (86.22% of all requests); held 12 requests (1.41%) in process; and denied 105 requests (12.37%). Of the requests denied, 20.95% of the requests were because the provider and MCP could not agree to a payment rate. Quarterly aggregate and MCP-level data is available in the attachment “Q3 2013 Continuity of Care.”

Plan-Reported Grievances (July 2013 – September 2013)

According to the data reported by MCPs operating under the Two-Plan and GMC models, SPDs submitted 1,714 grievances between July and September 2013. Of these grievances, 2.33% were related to physical accessibility, 8.34% were related to access to primary care, 3.56% were related to access to specialists, 1.28% were related to out-of-network services, and 84.48% were for other issues. Quarterly aggregate and MCP-level data is available in the attachment “Q3 2013 SPD Grievance.”

MERs Data (July 2013 – September 2013)

During 2013, from July through September, 3,363 SPDs submitted 5,809 MERs, an average of 1.73 MERs per SPD who submitted a MER. MMCD approved 3,951 MERs and denied 1,858. Due to the new process and tracking, the category “Incomplete” no longer exists. The top five MER diagnoses were Complex (675), Cancer (355), Transplant (198), Neurological (175), and Dialysis (97). Summary data is available in the attachment “Q3 2013 MERs Data.”

Health Plan Network Changes (July 2013 – September 2013)

According to the data reported by MCPs operating under the Two-Plan and GMC models, MCPs added 1,077 primary care physicians (PCPs) and removed 701 PCPs across all networks, resulting in a total PCP count of 21,843. Quarterly aggregate and MCP-level data is available in the attachment “Q3 2013 Network Adequacy,” including MCP-level changes in Specialists.

Financial/Budget Neutrality:

Nothing to report

Quality Assurance/Monitoring Activities:

SPD Evaluation (October 2013 – December 2013)

DHCS’s monitoring staff has reviewed all data collected to date and composed a list of recommended questions to include in the evaluation. In addition, DHCS hired consultants to provide a cost-value analysis of the SPD program before and after the SPD transition into MCPs. DHCS will submit a draft of the evaluation design to CMS for review in the beginning of 2014.

Encounter Data (October 2013 – December 2013)

DHCS initiated the Encounter Data Improvement Project (EDIP) in late 2012, with the goal of improving the current state of DHCS' encounter data as well as establishing the Encounter Data Quality Monitoring and Reporting Plan (EDQMRP). The EDQMRP, currently under development, is DHCS' plan for measuring encounter data, tracking it from submission to its final destination in the Department's data warehouse, and reporting data quality to internal and external stakeholders.

During the reporting period, the Encounter Data Quality Unit (EDQU), established by the EDIP, continued its efforts to implement and maintain the EDQMRP. EDQU continued to identify specific MCPs with missing encounter data and work with them to resolve the deficiencies. EDQU also continued to develop metrics that will objectively measure the quality of future encounter data in the dimensions of completeness, timeliness, reasonability and accuracy. On November 21, 2013, EDQU held its first quarterly Encounter Data Technical Assistance Workgroup webinar to introduce these quality measures to Medi-Cal MCPs and to solicit feedback as well. EDQU continued to work with other areas of DHCS to establish business requirements for an improved system being developed to receive encounter data from Medi-Cal MCPs. Concurrently, EDQU worked with DHCS' contracted fiscal intermediary to fix malfunctioning encounter data edits in the existing system. Although many of these efforts did not specifically target SPDs, improving the quality of DHCS' encounter data will enable better monitoring of the services and care provided to this population.

Outcome Measures and Avoidable Hospitalizations (October 2013 – December 2013)

DHCS employs multiple strategies to facilitate positive outcomes of care, including reduction in avoidable hospitalizations for all MCP members, including SPDs:

Healthcare Effectiveness Data Information Set (HEDIS) Measures

For services delivered in 2012 (HEDIS reporting year 2013), those MCPs with rates below the Minimum Performance Level (MPL)—defined as the 25th percentile of Medicaid health plans nationwide—have submitted Improvement Plans (IPs). The IPs are currently under review by DHCS staff, which has planned technical assistance calls help MCPs make progress on their IPs. HEDIS reporting year 2013 was the first year that the HEDIS data reflected SPDs. DHCS considers these results preliminary because not all SPDs had transitioned into MCPs by January 1, 2013. Beginning with HEDIS reporting year 2014, DHCS intends to provide SPD-specific results and comparisons to the non-SPD population for a subset of measures. DHCS will release the final HEDIS measures for 2014 (measurement year 2013) in January 2014.

Consumer Assessment of Healthcare Providers and Systems

During calendar year 2013, DHCS, through its external quality review organization (EQRO), administered the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys. The survey closed in May with a response rate of 35% for adults and 39% for children. DHCS will publish the final report in the first quarter of 2014.

Statewide Collaborative All Cause Readmissions

The Statewide Collaborative Quality Improvement Project (QIP) began in July 2011 and focused on reducing readmissions due to all causes within 30 days of an inpatient discharge among MCP members. DHCS worked with MCPs and DHCS's EQRO, Health Services Advisory Group, Inc. (HSAG), to develop guiding principles, a HEDIS-like measure specific to the Medi-Cal population, and a collaborative evaluation plan.

The baseline submissions for the all cause readmissions collaborative QIP were due from all MCPs by September 30, 2013. HSAG is currently completing the process of validating these submissions; this process includes a series of technical assistance calls with several MCPs.

Case Management and Coordination of Care Survey

Nothing to report.

State Audits

Nothing to report.

Utilization Data (October 2012 – December 2012)

During the period October through December 2012, MCPs in Two-Plan and GMC counties enrolled 526,444 unique SPDs. Below is a breakdown of the SPD utilization of services.

Regarding ER services:

- 13.02% (68,556) of the SPD population visited the ER.
- Each SPD that visited the ER went an average of 1.69 times.
- Each SPD that visited the ER generated an average of 2.7 ER claims.

Regarding pharmacy services:

- 68.41% (360,127) of the SPD population accessed pharmacy services.
- Each SPD that accessed pharmacy services generated an average of 13.41 claims.

Regarding outpatient services:

- 46.35% (244,002) of the SPD population accessed outpatient services.
- Each SPD that accessed outpatient services generated an average of 6.3 visits.
- Each SPD that accessed outpatient services generated an average of 9.75 claims.

Regarding inpatient services:

- 4.98% (26,208) of the SPD population accessed inpatient services.
- Each SPD that accessed inpatient services generated an average of 3.06 visits.
- Each SPD that accessed inpatient services generated an average of 3.6 claims.

Regarding hospital admissions:

- 5.69% (29,945) of the SPD population were admitted to a hospital.
- Each SPD admitted to a hospital generated an average of 2.18 visits.

Top Ten Services Accessed by SPDs

11,241,795 total claims

	Oct 2012 – Dec 2012
1	Prescribed Drugs
2	Physicians
3	Lab and X-Ray
4	Other Clinics
5	Other Services
6	Outpatient Hospital
7	Personal Care Services
8	Hospital: Inpatient Other
9	Targeted Case Management
10	Rural Health Clinics

For the top ten diagnosis categories, MCPs submitted data for a total of 2,660,343 encounters. Mental Illness was in the top rank with 35.93% of the encounters. “Symptoms; signs; and ill-defined conditions and factors influencing health status” accounted for 16.8%. In the third position, “Diseases of the circulatory system” was 8.21%. The remaining seven categories ranged from 8.16% to 3.09% of the encounters.

Quarterly aggregate and MCP-level data is available in attachment “DY9 Q2 Utilization Data.”

Enclosures/Attachments:

- “DY9 Q2 Defaults Transfers 2Plan GMC”
- “DY9 Q2 Ombudsman Report”
- “DY9 Q2 State Hearing Report.
- “Q2 2013 Risk Data”
- “Q3 2013 Continuity of Care”
- “Q3 2013 SPD Grievance”
- “Q3 2013 MERs Data”
- “Q3 2013 Network Adequacy”
- “DY9 Q2 Utilization Data”
- “MMCD AG Meeting Minutes December 12 2013 meeting”

CALIFORNIA CHILDREN SERVICES (CCS)

The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, and traumatic injuries.

The CCS program is administered as a partnership between local CCS county programs and the Department of Health Care Services (DHCS). Approximately 75 percent of CCS-eligible children are also Medi-Cal eligible.

The pilot projects under the Bridge to Reform Demonstration Waiver will focus on improving care provided to children in the CCS program through better and more efficient care coordination, with the goals of improved health outcomes, increased consumer satisfaction and greater cost effectiveness, by integrating care for the whole child under one accountable entity. Existing state and federal funding will be used for the pilot projects, which are expected to serve 15,000 to 20,000 CCS eligible children. The positive results of these projects could lead to improved care for all 185,000 children enrolled in CCS.

The projects are a major component of the Bridge to Reform's goal to strengthen the state's health care delivery system for children with special health care needs. The pilot projects will be evaluated to measure outcomes for children served. DHCS will use the results of the evaluation to recommend next steps, including possible expansion.

Under a competitive bid contracting process utilizing a Request for Proposals (RFP) document, DHCS, with the input of the CCS stakeholder community solicited submission of proposals to test four specific health care delivery models for the CCS Program. These included an existing Medi-Cal Managed Care Organization (MCO); a Specialty Health Care Plan (SHCP); an Enhanced Primary Care Case Management Program (E-PCCM); and an Accountable Care Organization (ACO). DHCS received five proposals and released Letters of Intent to Award a contract to the entities listed below.

1. Health Plan of San Mateo: Existing Medi-Cal Managed Care Organization
2. Los Angeles Health Care Plan: Specialty Health Care Plan
3. Alameda County Health Care Services Agency: Enhanced Primary Care Case Management Program
4. Rady Children's Hospital: Accountable Care Organization
5. Children's Hospital of Orange County: Accountable Care Organization

Enrollment information:

The current quarter monthly enrollment for Health Plan of San Mateo (HPSM) is shown in the table that follows. Please note that these numbers are based on Capitation Eligibles from the monthly CAPMAN invoices. Eligibility is derived from the Children's Medical Services Network (CMSNet) system, verified by Information Technology Services Division (ITSD) using Medi-Cal Eligibility Data System (MEDS) and forwarded to Office of HIPAA Compliance (OHC) where the file is sent to HPSM and an invoice is generated from the CAPMAN system.

Month	HPSM Enrollment Numbers	Difference
Prior Quarter September 2013	1,369	
October 2013	1,375	6
November 2013	1,413	38
December 2013	1,479	66

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

DHCS continues to collaborate with all five Demonstration entities relative to issues and challenges specific to each of the model locations. A challenge that impacts four of the five Demonstrations is capitation rates, the specific populations to be covered and the plans network. Other challenges are issues that are specific to each location such as covered populations and health conditions, general organizational structure, reporting requirements, etc.

HPSM Demonstration Project***Department Communications with CMS***

DHCS participates in pre-scheduled reoccurring meetings with CMS which includes CMS Region IX staff, CMS Central Office staff, and other DHCS organizations who are participating in other components of the 1115 Bridge to Reform Waiver. The Department's Systems of Care Division (SCD) also maintains separate communications with CMS Regional IX staff relative to issues for any of CMS's requirements.

Department Communications with HPSM

On October 10, 2013, SCD Management had a conference call with HPSM to discuss HPSM's System Approach, county billing questions, status of enrolling all CCS children into the pilot, and changes to the reporting schedule in HPSM's contract.

Due to DHCS's many pressing projects, the long-term system development to automate the addition of the CCS-Only population to health plans has been delayed. However, SCD is working on an interim manual process to add this population to HPSM.

Capitated Reimbursement Rates

SCD is in the process of enrolling the CCS-Only children in San Mateo County into the HPSM CCS Demonstration Pilot. The goal is to automate enrolling the CCS-Only children and for payment to occur through the Capitated Payment System for Medi-Cal Managed Care (CAPMAN). This system provides a functionality that allows business users to manage the Capitation Payment process from end to end. However, the process is intricate, and in the meantime SCD is manually enrolling and invoicing the HPSM Demonstration.

Rady Children's Hospital of San Diego (RADY) Demonstration Project

Capitated Reimbursement Rates

Continuing from mid-October 2011, DHCS has been working on development of reimbursement rates with DHCS's actuarial contractor, Mercer. RADY has requested that Mercer supply the rates for their review, however RADY wants to exclude some services that the Department included in their Request for Proposal. SCD Management has had communications with Mercer regarding the development of the requested rates once an agreement on the services is reached.

Children's Hospital Orange County (CHOC) Demonstration Project

Department Communications with CHOC

On October 2013, CHOC directly contacted DHCS/Agency requesting the latest draft version of the contract. SCD Management is in communication with both Medi-Cal Managed Care Division (MMCD) and CalOptima regarding the status of the draft contract.

Pilot Schedule

There is no projected starting date for the four remaining pilot models at this time.
Rady Children's Hospital of San Diego County (RADY)
Los Angeles Care Health Plan (LA Care)
Children's Hospital of Orange County (CHOC)
Alameda County Health Care (Alameda)

A challenge that impacted four of the five Demonstrations was access to cost utilization data required by these entities to adequately determine financial risk. Other challenges are issues that are specific to each location such as covered populations and health conditions, general organizational structure, reporting requirements, etc.

It should be noted that the projected implementation time table for each of the Demonstration Projects is contingent on a number of factors including acceptance of

reimbursement rates by the contracting entity, the ability of the contractor to demonstrate readiness to begin operations, and approval of the contract by CMS.

Additionally, DHCS has had numerous conference calls with each of the awardees in this quarter to discuss challenges or updates.

RADY - Completion and agreement of capitated reimbursement rates; confirmation of health conditions; possibility of additional health conditions for the future; and member and health plan notification.

CHOC – Providing claims data to CHOC consistent with the HIPAA security and confidentiality requirements; completion and agreement of capitated reimbursement rates; and confirmation of 10 health conditions, which may be reduced.

LA Care - Status of the Knox-Keene Wavier amendment approval with DMHC; providing claims data to LA Care consistent with the HIPAA security and confidentiality requirements; completion and agreement of capitated reimbursement rates; infrastructure challenges associated with three individual provider networks; coordination with other initiatives (coordinated care initiative, dual population, healthy family transition, Affordable Care Act); coordination with local CCS Program / eligibility and enrollment.

Alameda – Providing claims data to Alameda consistent with the HIPAA security and confidentiality requirements; completion and agreement of capitated reimbursement rates; confirmation of population (high acuity focus vs. entire population); and confirmation of administrative infrastructure.

Complaints, Grievances, and Appeals

On December 31, 2013, HPSM submitted a “Pending and Unresolved Grievances and Appeals Quarterly Report” (Grievances and Appeals Report) for the third quarter, July - September 2013. The Grievances and Appeals Report shows during the quarter:

- 0 grievances and appeals were received
- 1 grievance and appeal was resolved (Benefits Package for Vision)

The Grievances and Appeals Report further disseminates the types of grievances/appeals that are tracked and follow: Coverage Disputes, Medical Necessity Disputes, Quality of Care, and Access to Care (including appointments).

The report also tracks those categories for Grievances and Appeals that are resolved and follow: Fraud and Abuse, Enrollment/Disenrollment, Benefit Package, Access, Customer Care, Appeals, Other, and Timely Decisions.

Consumer Issues:

Nothing to report

Financial/Budget Neutrality:

Enrolling CCS-Only

SCD has met with ITSD, Medi-Cal Eligibility Division (MCED) and OHC multiple times during this quarter to enroll the CCS-Only children into San Mateo County into the HPSM CCS Demonstration Pilot. The goal is to have an automated process with invoicing occurring through CAPMAN. However, the automated process will take several months to implement. In the meantime, SCD has been manually enrolling and invoicing the HPSM Demonstration.

On October 10, 2013, SCD Management had a conference call with HPSM stating that SCD was working on an interim manual system. SCD has drafted a “high-level” flow chart on how the division envisions this occurring. SCD Management agreed to share a copy of this flow chart, so HPSM could review and see if this appears to be feasible to them as well.

Quality Assurance/Monitoring Activities:

During the October 10, 2013 SCD Management conference call with HPSM, HPSM had provided a copy of proposed changes to the contractual report requirements. During the discussion, SCD Management stated they were willing to reduce the multiple reports (monthly, quarterly, and semi-annual). DHCS will determine which of the reports are required by CMS, Statute, or RFP.

On November 26, 2013, HPSM submitted required contractual reports, “Enrollment and Utilization Table” for two quarters. Please refer to the table below.

Quarter	Total Enrollees At End of Previous Period	Additions During Period	Terminations During Period	Total Enrollees at End of Period	Cumulative Enrollee Months for Period
4/1/2013 – 6/30/2013	0	1,474	116	1,358	3,951
7/1/2013 – 9/30/2013	1,358	140	130	1,368	4,093

Evaluations:

Nothing to report.

Enclosures/Attachments:

Attached enclosure “California Children Services (CCS) Member Months and Expenditures” consisting of Number of Member Months in a Quarter, Number of Unique Eligibles Based on the First Month of Eligibility in the Quarter, and Expenditures Based on Month of Payment.

LOW INCOME HEALTH PROGRAM (LIHP)

The Low Income Health Program (LIHP) includes two components distinguished by family income level: Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI). MCE enrollees have family incomes at or below 133 percent of the federal poverty level (FPL). HCCI enrollees have family incomes above 133 through 200 percent of the FPL. Local LIHPs may elect to operate only an MCE program, but must operate a MCE in order to implement a new HCCI. The local LIHP can set the income levels below the maximum allowable amount according to the Special Terms and Conditions (STCs) approved by the Center for Medicare and Medicaid Services (CMS).

In addition to being classified by family income, enrollees are designated as “Existing” or “New” based on guidelines set forth in the STCs. Existing MCE or HCCI enrollees are enrollees whose enrollment was effective on November 1, 2010. An existing enrollee continues to be considered existing even as the enrollee may move from one component of the program to the other based on changes in the enrollee’s FPL. After an existing enrollee is disenrolled, he/she will be considered a new enrollee if he/she re-enrolls at a later date.

New MCE or HCCI enrollees are enrollees whose enrollment was effective after November 2010. This includes enrollees who were enrolled during the period legacy counties with prior HCCI programs transitioned from the HCCI to the LIHP. Legacy counties had the flexibility to continue enrollment during this transition period. Santa Clara County did not enroll new applicants until July 1, 2011.

Enrollment is effective on the first of the month in which the application was received except for a non-legacy LIHP that did not have a HCCI Program prior to November 1, 2010, and implemented the LIHP after the first of a month. During this first month of implementation, the enrollment effective date is the date the local LIHP was implemented. After this initial implementation month, enrollment follows the normal effective date of the first of the month.

Additionally, non-legacy LIHPs which offer retroactive enrollment from one to three months follow the same process. The enrollment cannot be retroactive beyond the implementation date until the one to three month timeframe has passed beyond the implementation date.

Enrollment Information:

The Quarterly LIHP enrollment report, applicant report, and the grievances and appeals report will be submitted to CMS in a separate note.

Outreach/Innovative Activities:

In preparation for next quarter's LIHP transition to Medi-Cal and Covered California eligibility on January 1, 2014, Department of Health Care Services (DHCS) offered a series of educational webinars during this quarter for physicians and other providers. The webinars offered are listed below. If you would like to view the webinars, please visit <http://www.dhcs.ca.gov/provgovpart/Pages/LIHPProviderWebinars.aspx>.

- General Provider Training for the LIHP Transition – November 14, 2013
- Navigating the LIHP Transition in a County Operated Health System (COHS) – November 20, 2013
- LIHP Patients, Providers, and Managed Care Assignment – November 21, 2013
- Mental Health & Substance Use Disorder Treatment Needs During the LIHP Transition – November 26, 2013
- Complex & Chronic Conditions: Managing the LIHP Transition – December 3, 2013

Operational/Policy Issues:

DHCS initiated a request in early December to have all LIHPs enter into Data Use Agreements that would extend the Business Associate Addendum (BAA) in the LIHP contract to allow the continued exchange of protected enrollee information after the original LIHP contracts expire on December 31, 2013.

DHCS continued working on a request by Alameda that would allow Alameda County Medical Center, a designated public hospital, to report Certified Public Expenditures (CPE) to Alameda LIHP for the period of November 1, 2010 – June 30, 2011 under Attachment G Supplement 1, Section K, as an Other Governmental Entity.

DHCS set up a new code within the Information Technology Services Division (ITSD) for their use, for the purpose of capturing ITSD's costs associated with the LIHP transition that will be distributed among all 19 LIHPs.

DHCS continued to provide technical expertise and recommendations for development, implementation, evaluation, and monitoring of activities to optimize federal financial participation (FFP) and maximize financial resources to the counties.

DHCS continued to develop a contracting process with all 19 LIHPs, for reimbursement of costs incurred by DHCS related to inputting LIHP data into the Statewide Medi-Cal Eligibility Data Systems (MEDS).

DHCS continued to work with the California Department of Public Health, Office of AIDS (OA), to ensure the smooth transition of eligible Ryan White clients currently in LIHP to Medi-Cal or Covered California eligibility. In addition, the following activities regarding the Delivery System Reform Incentive Pool (DSRIP) Category 5 HIV Transition Projects occurred during this quarter:

- DHCS reviewed the DSRIP plan modification from the Designated Public Hospitals (DPHs) in San Francisco and Los Angeles counties and submitted these plan modifications to CMS for review.
- Plan modifications for Alameda, Contra Costa, Kern, Los Angeles, San Diego, San Francisco, and Santa Clara counties were approved by CMS.
- DPHs submitted their annual reports on October 31, 2013.
- DHCS reviewed the DPHs second semi-annual reports and annual reports.

DHCS continued collaboration with the University of California Los Angeles (UCLA), Center for Health Policy Research, the independent evaluator for the LIHP, to verify and correct data reports that are used to monitor and measure the effectiveness of the local LIHPs.

DHCS collaborated with UCLA to plan the revisions to the expansion website architecture to increase accessibility for the public to the LIHP utilization and demographic data by county on the UCLA Center for Health Policy Research web site.

DHCS collaborated with UCLA in drafting and reviewing reports and publications for the LIHP component of the Demonstration and the Final HCCI Evaluation report.

DHCS staff and UCLA worked to develop an interagency agreement for the remaining years of the LIHP evaluation and LIHP transition activities. The final interagency agreement is under review by DHCS and UCLA.

DHCS continued reviewing a draft protocol regarding the cost claiming process for mental health services provided by non DPH-based LIHPs, other than mental health services provided at a hospital operated by a non DPH-based LIHP, including services provided in a subcontract. This specific protocol is required pursuant to Attachment G, Supplement 1, Section F, of the Special Terms and Conditions.

CMS approved Attachment J, LIHP Administrative Activities Claiming Protocol and Implementation Plan. Local LIHPs began conducting time study surveys and submitting their claiming plans in accordance with the Attachment J Implementation Plan for DHCS' review.

DHCS continued planning for the Primary Care Provider (PCP) bump increased payment per the CMS ruling 42 CFR Part 438, 441, and 447 which entitles the LIHPs to receive the difference of the increased amount for the calendar year 2013. Section 1902(a)(13)(C) of the Act "requires the states pay a minimum payment amount for certain primary care services delivered by designated primary care physicians. Primary

care services are defined in the new section 1902 (jj) of the Act and include certain specified procedure codes for evaluation and management (E&M) services and certain vaccine administration codes. Under this provision, states must reimburse at least as much as the Medicare physician fee schedule (MFPS) rate in CYs 2013 and 2014 or, if greater, the payment rate that will apply using the CY 2009 Medicare CF.”

DHCS continued planning the LIHP transition to Medi-Cal and Covered California eligibility on January 1, 2014. Specific tasks and activities including but are not limited to:

- DHCS distributed notices for HCCI Covered California; 60-day choice notices were sent in early November, and 30-day choice reminders were sent in early December to LIHP enrollees.
- DHCS estimated and planned the production and distribution of Medi-Cal identification cards and “Welcome to Medi-Cal” packets.
- DHCS collaborated with UCLA on transition planning and provision of LIHP data for rates and medical home assignment for the LIHP transition.
- DHCS collaborated with Covered California regarding notices and transition of HCCI enrollees.
- DHCS conducted teleconferences with the local LIHPs and provided guidance on the transition process and data sharing with the health plans.
- DHCS completed LIHP Data Transition Monthly Reports and compiled monthly reports from local LIHPs to determine the status on providing LIHP enrollee information into MEDS to assist with the LIHP transition.

A revised LIHP Inmate PPL was released during the quarter. The PPL reflected overall changes and developments in the inmate program and language to align the services with those described in Attachment G, Supplement 1, of the Bridge to Reform Demonstration waiver.

Currently 17 of 19 operational local LIHPs have executed contracts with the California Correctional Health Care Services (CCHCS), which provide the eligibility and claiming process for state populations determined eligible for LIHP by DHCS. Monterey and Santa Clara counties have pending contracts with CCHCS. DHCS continues to provide technical assistance to the local LIHPs regarding this process.

Consumer Issues:

DHCS continued to conduct and/or participate in the following stakeholder engagement processes during the quarter. These processes will continue as needed after the LIHP Transition on January 1, 2014 to ensure that LIHP enrollees are successfully transitioned to Medi-Cal or Covered California eligibility:

- DHCS staff participated in the planning of the curriculum, slides, and presentations for Community Based Organization trainings on the LIHP Transition in Redding and San Diego counties.

- Weekly teleconferences with the DHCS Transition Workgroup, University of California – Berkeley, and University of California – Los Angeles to coordinate and strategize on UC contractual work activities for the transition of LIHP enrollees into Medi-Cal January 1, 2014.
- Weekly teleconferences with the local LIHP counties to address important questions relating to the LIHP program and transition activities.
- Quarterly teleconferences with advocacy groups to address questions and concerns regarding the LIHP program.
- Bi-weekly meetings of the LIHP/OA Stakeholder Advisory Committee (SAC) to discuss issues related to the transition of individuals diagnosed with HIV and receiving health care services through the Ryan White programs, to health care coverage under LIHP and Medi-Cal. In addition, the LIHP Division meets with OA on a bi-weekly basis to confer on and respond to issues raised by the SAC and other stakeholders.
- Weekly LIHP/Medi-Cal Eligibility Division/Safety Net Financing Division/California Department of Corrections and Rehabilitation (CDCR) CCHCS, for discussion on populations determined eligible for Medi-Cal and LIHP by DHCS.

DHCS continues to provide guidance to and solicit feedback from stakeholders and advocates on program policy concerns, and to respond to issues and questions from consumers, members of the press, other state agencies, and legislative staff through the LIHP e-mail inbox and telephone discussions. DHCS continues to maintain the LIHP website by updating program information for the use of stakeholders, consumers, and the general public.

Financial/Budget Neutrality:

LIHP Division Payments					
Payment Type	FFP Payment	Other Payment (IGT)	(CPE)	Service Period	Total Funds Payment
CDCR (Qtr 2)	\$28,628	\$0.00	\$57,256	DY 7	\$28,628
	\$2,782,967		\$5,565,934	DY 8	\$2,782,967
	\$1,145,730		\$2,291,460	DY9	\$1,145,730
Health Care (Qtr 2)	-\$845,041		-\$1,690,082	DY 7	-\$845,041
	\$112,086,652		\$224,173,304	DY 8	\$112,086,652
	\$172,295,221		\$344,590,442	DY9	\$172,295,221
	\$34,502,252	\$34,502,252		DY7	\$69,004,504
	\$2,774,640.50	\$2,774,640.50		DY8	\$5,549,281
Total	\$324,771,049.50	\$37,276,892.50	\$574,988,314		\$362,047,942

Quality Assurance/Monitoring Activities:

DHCS developed and distributed contract compliance materials for LIHPs submission. DHCS reviewed the LIHP submissions for contract compliance and corresponded with LIHPs as needed to ensure compliance in the following areas:

- General LIHP Contractor Provisions
- Quality Improvement Provisions
- Utilization Management Provisions
- Enrollee Rights & Services Provisions
- Privacy Provisions

DHCS continues to monitor the quarterly grievances and appeals reports from the local LIHPs and follows up with them on any potential program compliance problems affecting LIHP enrollees' access to program services.

Enclosures/Attachments:

- Yr3Q2 Evaluation Design Progress Report Oct 1 2013 - Dec 31 2013

FINANCIAL/BUDGET NEUTRALITY

Payment	FFP Payment	Other (IGT)	(CPE)	Service Period	Total Funds Payment
Designated Public Hospitals					
SNCP					
(Qtr 1)	\$ 0		\$ 0	DY 7	\$ 0
(Qtr 1)	\$ 32,166,667		\$ 32,166,667	DY 8	\$ 64,333,334
(Qtr 1)	\$ 77,749,999		\$ 77,749,999	DY 9 (Jul-Sept)	\$ 155,499,998
(Qtr 2)	\$ 77,750,000		\$ 77,750,000	DY 9 (Oct-Dec)	\$ 155,500,000
Total:	\$ 187,666,666		\$ 187,666,666		\$ 375,333,332
DSRIP					
(Qtr 2)	\$ 1,061,212.50	\$ 1,061,212.50		DY 7	\$ 2,122,425.00
(Qtr 2)	\$ 367,054,154.24	\$ 367,054,154.24		DY 8 (Jan-Jun)	\$ 734,108,308.38
Total:	\$ 368,115,366.74	\$ 368,115,366.74			\$ 736,230,733.38
Designated State Health Program (DSHP)					
Payment	FFP Claim		(CPE)	Service Period	Total Claim
State of California					
(Qtr1)	\$ 41,382,406		\$ 82,764,811	DY 9 (Jul-Sept)	\$ 41,382,406
(Qtr2)	\$ 84,446,462		\$ 168,892,925	DY 9 (Oct-Dec)	\$ 84,446,462
Total:	\$ 125,828,868		\$ 253,339,387		\$ 125,828,868

I. DESIGNATED STATE HEALTH PROGRAM (DSHP) UPDATE

Program costs for each of the Designated State Health Programs (DSHP) are expenditures made through the Safety Net Care Pool (SNCP) for uncompensated care provided to uninsured individuals with no source of third party coverage. Under the waiver, the State receives federal reimbursement for programs that would otherwise be funded solely with state funds. Expenditures are claimed in accordance with CMS-approved claiming protocols.

This quarter, Designated State Health Programs claimed \$ 84,446,462 in federal fund payments for SNCP eligible services.

II. SAFETY NET CARE POOL UNCOMPENSATED CARE UPDATE

Expenditures may be made through the Safety Net Care Pool (SNCP) for uncompensated care provided to uninsured individuals with no source of third party coverage for the services they received, furnished by the hospitals or other providers identified by the State. Expenditures are claimed in accordance with CMS-approved claiming protocols.

This quarter, designated public hospitals received \$ 77,750,000 in federal fund payments for SNCP eligible services.

California Children Services (CCS) Member Months and Expenditures

- California Children Services – Excludes CCS State-Only and CCS Healthy Families Only Eligibles
- Expenditures and Eligibles by Specific Time Periods
- Eligibility Sources: CCS/GHPP Eligibility Table on MIS/DSS for Active CCS Clients with a Medi-Cal Aid Code.
- Expenditure Source: MIS/DSS (Age between 0 and 20, Claim Source Code = 19 EDS Fee-For-Service Medi-Cal)

- **Note: Since payments are based on payment date, this data cannot be used to calculate cost per member per month.**

Report Number	Time Period	Number of Member Months in a Quarter	Number of Unique Eligibles Based on the First Month of Eligibility in a Quarter	Expenditures Based on Month of Payment
DY6, Q1	September – December 2010	551,505	138,443	\$829,406,465
DY6, Q2	January – March 2011	406,113	135,693	\$676,468,735
DY6, Q3	April – June 2011	404,674	134,774	\$649,757,648
DY7, Q1	July – September 2011	408,149	135,612	\$570,379,382
DY7, Q2	October – December 2011	403,452	135,812	\$592,896,974
DY7, Q3	January – March 2012	405,879	136,489	\$639,248,570
DY7, Q4	April – June 2012	409,451	137,496	\$574,933,670
DY8, Q1	July – September 2012	404,973	135,775	\$565,527,403
DY8, Q2	October – December 2012	409,169	137,698	\$442,066,945
DY8, Q3	January – March 2013	426,875	142,507	\$382,433,183
DY8, Q4	April - June 2013	457,711	152,598	\$349,532,016
DY9, Q1	July – September 2013	449,582	149,612	\$433,168,578
DY9, Q2	October – December 2013	457,645	153,488	\$296,658,524